DEPARTMENT OF THE NAVY
NAVAL HOSPITAL
BOX 788250
MARINE CORPS AIR GROUND COMBAT CENTER
TWENTYNINE PALMS, CALIFORNIA 92278-8250

IN REPLY REFER TO:
NAVHOSP29PALMSINST 6320.74B
Code 0905
24 April l995

NAVAL HOSPITAL TWENTYNINE PALMS INSTRUCTIONS 6320.74B

From: Commanding Officer

Subj: THIRD PARTY COLLECTION PROGRAM (TPCP)

Ref: (a) Title 10, United States Code 1095
(b) DoD Instruction 6010.15 Series
(c) BUMEDINST 7000.7 Series
(d) NAVMED p-5020

Encl: (l) Third Party Collection Program - Insurance Information, DD Form 2569

l. Purpose. To establish basic procedures for billing and collection of insurance from third party payers and to assign responsibility for program management.

2. Cancellation. NAVHOSP29PALMSINST 6320.74A.

3. Background. Reference (a), amended in 1991, authorizes Department of Defense hospitals to bill commercial private insurance companies for health care services provided to uniform service beneficiaries. The program is designed to bring additional revenues to the hospital without any additional charges being incurred by our beneficiaries. Patients are not required to pay any deductibles o co-payments and all these additional revenues will come solely from the commercial private health insurance companies. The funds collected remain at the hospital to be used to enhance patient care.

4. Policy. It is the responsibility of the Commanding Officer to ensure that an aggressive TPCP is implemented and carried out. At this Command, the program management responsibilities are delegated to the Head, Fiscal Department. The Head, Fiscal Department, works closely with the Patient Administration Department, Nursing Services and the medical staff to ensure a comprehensive program is carried out in accordance with references (a) through (c).

5. Action

a. Head, Patient Administration Department shall:

(1) Ensure enclosure (l) is completed for all patients presenting themselves for admission, pre-admission and same day surgery.

(2) Ensure a copy of enclosure (l) and a copy of the patient's insurance card are forwarded to the Fiscal Department on a daily basis.

(3) Ensure all information from enclosure (l) is accurately entered into the CHCS computer system.

b. Outpatient Clinics shall ensure enclosure (l) is completed for all new patients and mark the outpatient record for insurance identification (i.e, colored sticker). Clinic personnel must also ask patients with previously marked records if the insurance information is current.

c. Third Party Collection Clerk shall:

(l) Bill private commercial insurance companies for care provided to insured beneficiaries in accordance with references (b) through (d).

(2) Liaison with the Utilization Management Coordinator on questions concerning authorized admissions.

(3) Follow-up on denied claims and delinquent accounts receivables.

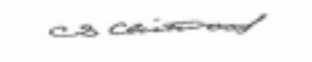
(4) Provide monthly reports to higher authority as prescribed in reference (c).

(5) Provide instruction on TPCP procedures to staff members.

6. Applicability. The instruction is applicable to all personnel aboard Naval Hospital, Twentynine Palms, California.

7. Required reports. The Third Party Collection Report, # 6320-74, is due to Healthcare Support Office, San Diego, California, and Bureau of Medicine and Surgery, Washington, D. C., by the fifteenth of each month.

8. Required forms. Third Party Collection Program - Insurance Information, DD Form 2569, may be obtained through Central Files.



C. S. CHITWOOD

Distribution:
List A

THIRD PARTY COLLECTION PROGRAM - INSURANCE INFORMATION

(Read Privacy Act Statement on back before completing this form.)

Form Approved
OMB No. 0704-0323

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO EITHER OF THESE ADDRESSES. RETURN COMPLETED FORM TO REQUESTING MEDICAL TREATMENT FACILITY

SECTION I - PATIENT INFORMATION

1. NAME *(Last, First, Middle Initial)*	2. PATIENT SSN	3. DATE OF BIRTH *(YYMMDD)*
4. ADDRESS *(Street, City, State and Zip Code)*	5. TELEPHONE NUMBER *(Include Area Code)* a. HOME b. OFFICE	6. SPONSOR'S BRANCH OF SERVICE 7. FAMILY MEMBER PREFIX (FMP) / SPONSOR SSN 8. RELATION OF PATIENT TO INSURED

9. IS PATIENT'S CONDITION RELATED TO AN ACCIDENT?	☐ YES *(Complete a.-e.)*	☐ NO *(Complete d.-e.)*		
a. TYPE OF ACCIDENT *(X one)* ☐ AUTO ACCIDENT *(Comply with information requirements as stated in DoDI 6010.15)* ☐ OTHER	b. DATE OF ACCIDENT *(YYMMDD)*	c. HOUR	d. DATE OF ADMISSION/ VISIT *(YYMMDD)*	e. HOUR

f. IS PATIENT COVERED BY ANY MEDICAL INSURANCE? ☐ YES ☐ NO *(If "Yes," complete Section II. If "No," go to Section IV.)*

SECTION II - INSURANCE CARRIER INFORMATION *(Complete for all Health Insurance policies and employers.)*

10. EMPLOYER OF INSURED

a. NAME	b. TELEPHONE NUMBER *(Incl. Area Code / Extension)*	c. ADDRESS *(Street, City, State and Zip Code)*

11. PRIMARY MEDICAL INSURANCE POLICY

a. INSURANCE TYPE *(X one)*		b. NAME OF INSURED *(Last, First, Middle Initial)*	c. SSN
☐ GROUP HEALTH PLAN	☐ CHAMPUS/CHAMPVA		
☐ COMMERCIAL	☐ SUPPLEMENTAL CHAMPUS		
	☐ SUPPLEMENTAL MEDICARE		

d. NAME OF GROUP INSURANCE PLAN *(If applicable)*			e. GROUP PLAN NUMBER
f. INDIVIDUAL POLICY NUMBER	g. GROUP POLICY NUMBER	h. EFFECTIVE DATE *(YYMMDD)*	i. RENEWAL DATE *(YYMMDD)*

j. COMMERCIAL INSURANCE COMPANY	k. FAMILY MEMBERS COVERED BY THIS POLICY		
(1) NAME	(1) NAME *(Last, First, Middle Initial)*	(2) DATE OF BIRTH *(YYMMDD)*	(3) SSN
(2) TELEPHONE NUMBER *(Include Area Code / Extension)*			
(3) ADDRESS *(Street, City, State and Zip Code)*			

12. OTHER MEDICAL INSURANCE POLICIES *(Use additional pages as necessary.)*

a. INSURANCE TYPE *(X one)*		b. NAME OF INSURED *(Last, First, Middle Initial)*	c. SSN
☐ GROUP HEALTH PLAN	☐ CHAMPUS/CHAMPVA		
☐ COMMERCIAL	☐ SUPPLEMENTAL CHAMPUS		
	☐ SUPPLEMENTAL MEDICARE		

d. NAME OF GROUP INSURANCE PLAN *(If applicable)*			e. GROUP PLAN NUMBER
f. INDIVIDUAL POLICY NUMBER	g. GROUP POLICY NUMBER	h. EFFECTIVE DATE *(YYMMDD)*	i. RENEWAL DATE *(YYMMDD)*

j. COMMERCIAL INSURANCE COMPANY	k. FAMILY MEMBERS COVERED BY THIS POLICY		
(1) NAME	(1) NAME *(Last, First, Middle Initial)*	(2) DATE OF BIRTH *(YYMMDD)*	(3) SSN
(2) TELEPHONE NUMBER *(Include Area Code / Extension)*			
(3) ADDRESS *(Street, City, State and Zip Code)*			

SECTION III - PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC, Sec. 1095; EO 9397.

PRINCIPAL PURPOSE(S): Information will be used to collect from private insurers for medical care provided to military dependents and retirees. Such monetary benefits accruing to the Military Medical Facility will be used to enhance health care delivery in the Medical Treatment Facility. Information will also be used by Military Treatment Facility staff and CHAMPUS Fiscal Intermediaries (FI's) to determine eligibility for care, deductibles, and co-shares.

ROUTINE USE(S): The information on this form will be released to your insurance company, and to Medical Treatment Facility staff, CHAMPUS FI's, and providers.

DISCLOSURE: Voluntary; however, failure to provide complete and accurate information may result in disqualification for health care services from facilities of the uniformed services and in a higher cost to you for medical care.

SECTION IV - RELEASE AND ASSIGNMENT

I acknowledge that portions of my medical records necessary to support claims for reimbursement for the cost of care rendered may be released to my insurance carriers.

I acknowledge that the authority to bill third party payers has been conveyed to the medical facility within the Department of Defense by Title 10 U.S. Code, Section 1095, and that no personal entitlement to reimbursement or payment has been granted to me by virtue of this act.

I hereby acknowledge that the proceeds of any and all benefits shall be paid directly to the facility of the Uniformed Service for hospitalization or outpatient services provided me and/or my dependents.

SECTION V - CERTIFICATIONS

I certify that the information on this form is true and accurate to the best of my knowledge.

a. SIGNATURE OF PATIENT OR ADULT FAMILY MEMBER/SPONSOR	b. DATE SIGNED *(YYMMDD)*
c. SIGNATURE OF CLERK	d. DATE SIGNED *(YYMMDD)*

SECTION VI - REGISTRATION VERIFICATION

NOTE: Verification of insurance coverage shall be made upon the occasion of each admission or outpatient visit to the Medical Treatment Facility. Any time information on this form is changed a new signature must be obtained. Annually, on the first visit after twelve months have passed since the patient's signature was first obtained, a new form must be completed and signed.

I certify that the information on this form has been verified on the date(s) specified below, and that all information is true and accurate to the best of my knowledge.

a. FIRST VERIFICATION (1) SIGNATURE	(2) DATE SIGNED *(YYMMDD)*
b. SECOND VERIFICATION (1) SIGNATURE	(2) DATE SIGNED *(YYMMDD)*
c. THIRD VERIFICATION (1) SIGNATURE	(2) DATE SIGNED *(YYMMDD)*
d. FOURTH VERIFICATION (1) SIGNATURE	(2) DATE SIGNED *(YYMMDD)*
e. FIFTH VERIFICATION (1) SIGNATURE	(2) DATE SIGNED *(YYMMDD)*
f. SIXTH VERIFICATION (1) SIGNATURE	(2) DATE SIGNED *(YYMMDD)*